STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

TITLE 28, CALIFORNIA CODE OF REGULATIONS
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE
CHAPTER 2. HEALTH CARE SERVICE PLANS
ARTICLE 2.5 DISCOUNT HEALTH PLANS

PROPOSED ADOPTION OF ARTICLE 2.5 COMMENCING WITH SECTION 1300.49.1.1
PROPOSED TEXT

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Article 2.5. Discount Health Plans

1300.49.1.1 Definitions

For purposes of this Article:

(a) The term "bona fide discount" means a discount that is not subject to terms and conditions which render the discount illusory; is amenable to documentation, verification, and enforcement by the discount health plan; and is otherwise in compliance with the requirements of this Article.

(b) The term "discount health plan" means a person who, in exchange for a prepaid or periodic charge paid by or on behalf of subscribers and enrollees, undertakes to arrange for discounts on health care services on behalf of subscribers and enrollees who retain the financial responsibility to pay the discounted cost of health care services. A solicitor, as defined in subsection (f), is not a discount health plan, unless the activities of the solicitor include those described in this subsection or Section 1345(f) of the Act.

(c) The term "discount health product" means the contract by which a discount health plan offers discounts on health care services. A discount health product that is offered free of charge as a stand-alone product, or as a free of charge adjunct to a non-discount health plan's licensed product, is not subject to these regulations.

(d) In addition to the definition at Section 1345(i) of the Act, the term "provider" includes providers, provider groups, contracted providers, and all providers listed in the directory provided to enrollees.

(e) The term "pharmacy" means a pharmacy, as defined in Section 4037 of the Business and Professions Code.

(f) In addition to the definition at Section 1345(m) of the Act, the term "solicitor" includes a person or entity that attaches its own private label name on any material distributed to consumers in connection with the discount health plan subscriber contract, including but not limited to the discount identification card, disclosure forms, and subscriber contracts.

(g) The term "value added services" means services, rewards, and items that promote wellness, such as massage services, and gym memberships, which are arranged for, or provided, at no additional charge by a licensed health care service plan to an enrollee in that plan's health care service plan product.

AUTHORITY: Section 1344, Health and Safety Code
REFERENCE: Section 1345, Health and Safety Code

1300.49.1.2 Licensing

(a) No person shall engage in business as a discount health plan or offer a discount health plan product in this state unless such person has first secured from the Director a license. The application for a discount health plan license shall be filed on the form in 28 CCR Section 1300.51.01. Any person violating this Section shall be subject to the full scope of the Department's powers and processes, including, but not limited to, the penalties referenced in Section 1387 of the Act.

(b) Prior to engaging in business as a discount health plan or offering a discount health product, a health care service plan with an existing license for non-discount services must either:

(1) Secure a separate license as required by subsection (a) of this section, if the type of discount health product differs from the type of plan contract(s), such as full service, dental, or vision, approved under the plan's license pursuant to 28 CCR Section 1300.51(c)(C); or

(2) File a notice of material modification in accordance with Section 1352 of the Act and 28 CCR Section 1300.52.1 in lieu of applying for separate licensure, if the type of discount health product is for the same type of plan contract(s) approved under the plan's license pursuant to 28 CCR Section 1300.51(c)(C). All plans filing a notice of material modification must attach the information and documents required by the form in 28 CCR Section 1300.51.01.

(c) The name of the discount health plan and discount health product shall clearly identify it as a discount health plan or discount health product.

(1) The name of any discount health plan or discount health product shall not contain any of the prohibited marketing terms in section 1300.49.1.3(f).

(2) The name of a discount health plan, or discount health product, must clearly distinguish it from non-discount health care plans and non-discount health care service products.

(A) No trade name used to identify a non-discount health care service plan shall be used to identify a discount health plan.

(B) No trade name used to identify a non-discount health care service product shall be used to identify a discount health product.

(d) Health care service plans licensed under the Act do not need to file a material modification or obtain a separate license in order to offer discounts on "value added services" as defined in this Article.

(e) A discount health plan shall demonstrate compliance with the standards and requirements of the Act and Title 28 California Code of Regulations regarding licensure and operations to the extent specified in this Article and in the discount health plan license application form set forth at Section 1300.51.01.

(f) This Article does not limit or otherwise affect any powers of the Director established by the Act, or the Department's review of a discount health plan consistent with any statement of legislative intent set forth in the Act. Discount health plans are subject to the full scope of the Department's powers and processes, including but not limited to licensing review, medical surveys, financial audit, and civil, criminal and administrative fines and penalties to the fullest extent as set forth in the Act and Title 28.

(g) A pharmacy, or chain of pharmacies, that offers discounts on its own services and products to customers in exchange for a prepaid or periodic charge paid by or on behalf of the customer to the pharmacy, or chain of pharmacies ("program"), is exempt from the requirements of this Article if all of the following conditions are met:

(1) The pharmacy, or chain of pharmacies, is not a wholesaler, as defined in Business and Professions Code Section 4043.

(2) The prepaid or periodic charge is only used to administer the program and not to generate a profit.

(3) The prepaid or periodic charge does not exceed $20 per person per year.

(4) The entity must provide written notice to the Director of its intent to rely on the exemption provided by this section, executed by a duly authorized officer of the entity. The entity must also notify the Director in writing of any material change that could change the entity's eligibility for the exemption.

(h) A wholesale membership club that, in exchange for a prepaid or periodic fee, offers its members access to discounts on services and products at pharmacies owned and operated by the wholesale membership club, is exempt from the requirements of this Article if all of the following conditions are met:

(1) The pharmacies owned and operated by the wholesale membership club do not constitute wholesalers, as defined in Business and Professions Code Section 4043.

(2) The wholesale membership club does not charge or require its members to pay an additional fee beyond the fee to become or remain a member in order to access discounts on services and products at pharmacies owned and operated by the wholesale membership club.

(3) The fee to become or remain a member of the wholesale membership club does not include a charge to access discounts on services and products at pharmacies owned and operated by the wholesale membership club.

(4) The entity must provide written notice to the Director of its intent to rely on the exemption provided by this section, executed by a duly authorized officer of the entity. The entity must also notify the Director in writing of any material change that could change the entity's eligibility for the exemption.

(i) A corporation which operates a network of independent motor clubs in the State of California licensed as motor clubs by the California Department of Insurance which offers discounts on pharmacy and pharmacist services to the members of the affiliated motor clubs ("program"), is, together with such affiliated motor clubs ("plan"), exempt from the requirements of this article if all of the following conditions are met:

(1) That the program shall be available solely to the members of the affiliated motor clubs;

(2) That members shall not be charged a fee ~~or~~ to become or remain members of the pharmacy plan, other than the annual membership dues for maintaining membership in the affiliated motor club, in order to have access to and use of the program;

(3) The ~~plan~~ corporation shall have a written agreement with a pharmacy benefits management company ("PBM") to administer the program, which shall require the PBM to contract with a network of licensed retail pharmacies located and operating in California to participate in the program. ~~The plan must maintain an adequate network of contracted pharmacies consistent with subsection 1300.49.1.5 of this section.~~

(4) That the network of participating retail pharmacies located in this State shall not fall below 75% of retail pharmacies licensed and operating in California.

~~(4)~~ (5) The affiliated motor clubs must be either party to, or third party beneficiaries of, the contract between the PBM and the corporation ~~plan~~;

~~(5)~~ (6) To address concerns and questions from members, the plan ~~must~~ shall maintain:
(i) ~~through its written agreement with a PBM~~, a pharmacist ~~and customer service staff~~ available at each network pharmacy during the pharmacy's regular hours of operation,
(ii) customer service staff available through a toll-free telephone line during regular business hours, and
(iii) an email address or website where enrollees may submit questions.

~~(6)~~ (7) The Certificate of Authority issued to the affiliated motor clubs by the California Department of Insurance must remain in full force and effect;

~~(7)~~ (8) The ~~entity~~ plan must provide written notice to the Director of its intent to rely on the exemption provided by this section, executed by a duly authorized officer of the ~~entity~~ plan. The ~~entity~~ plan must also notify the Director in writing of any material change that could change the ~~entity's~~ plan's eligibility for the exemption.

AUTHORITY: Sections 1343, 1344, and 1351, Health and Safety Code
REFERENCE: Sections 1349, 1351.1, 1351.3,1352, 1352.1,1353, and 1387, Health and Safety Code

1300.49.1.3 Marketing of Discount Health Plan Contracts

(a) A discount health plan shall file with the Department not less than 30 days prior to use, all advertising, marketing, and solicitation materials published or distributed in connection with enrollment in the plan, including all such materials distributed by solicitors or solicitor firms. All advertising and marketing materials shall clearly and prominently disclose:

(1) That the discount health product is not insurance.

(2) The name of the discount health plan. Material referencing any solicitor shall include disclosures clearly distinguishing the discount health plan from the solicitor and specifying that the contract is offered by the discount health plan.

(3) That the subscriber or enrollee may be required to pay for all health care purchases at the time health care services are rendered or health related items are received in order to receive the discount; and

(4) Discounts are only available from providers in the discount health plan network.

(b) When presenting any written individual subscriber contract for examination or sale, the plan or its solicitor shall also provide the disclosure form applicable to the contract and a directory of the plan's providers located in the subscriber's preferred geographic area. For purposes of this subsection, written contracts include subscriber contracts or enrollment forms distributed via facsimile, e-mail or Internet web site. The required disclosure form and relevant portion of the provider directory shall be provided through the same mode of distribution as the subscriber contract, except that, if the potential subscriber prefers, the provider directory may be provided through the plan's Internet web site.

(c) A discount health plan, or any discount health plan solicitor or solicitor firm which solicits enrollment of subscribers or enrollees by telephone, shall:

(1) Disclose, prior to enrollment, the availability of all disclosure forms required to be presented in connection with solicitation pursuant to this Article.

(2) Verbally disclose prior to enrollment all principal terms, conditions and exclusions and limitations under the subscriber contract.

(3) Document each telephone enrollment transaction, including all required verbal disclosures, in an audio recording, and retain the audio recordings, pursuant to Rule 1300.85.1, for not less than five years in a manner that enables the plan to retrieve a specific recording by date or subscriber name and to provide it to the Department not more than five days after request.

(4) The discount plan shall, no later than three business days following the telephone enrollment, send the enrollee a membership card and a paper copy of the full ~~evidence of coverage~~ disclosure and enrollment forms. These documents shall be sent either by mail or fax, or, if requested by the enrollee, by electronic mail.

(d) A discount health plan shall maintain a public website that includes a complete and accurate directory of all providers, which shall be updated not less than quarterly. The website shall allow user interaction to locate providers by specialty and geographic location.

(e) Prior to allowing any person to engage in acts of solicitation on its behalf, a discount health plan shall require all solicitors and solicitor firms to demonstrate either current licensure in good standing by the State of California as an insurance agent or broker, or completion of a solicitor training program required by the plan through which the solicitor or solicitor firm demonstrates competent knowledge of the marketing and solicitation requirements of this Article and Section 1300.51.01, and the ethical obligations of a solicitor. A plan may demonstrate compliance with this training requirement through administration of the plan's training program to all solicitors and solicitor firms or, in the alternative, to the supervisory employees of a solicitor or solicitor firm, if the trained supervisory employees are obligated to train all other employees of the solicitor or solicitor firm who solicit on behalf of the plan.

(f) A discount health plan shall not use or permit the use of any advertising or marketing material that includes terms that may mislead an individual into believing that the discount health product is health insurance. Prohibited terms include, but are not limited to, "insurance," "HMO," "coverage," "copay," "copayments," "deductible," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or "agent." This subsection does not prohibit use of these terms in specific disclosures required by this Article or other provisions of law, when they are used in discount product informational materials describing the differences between discount health products and insurance, or as otherwise approved by the Department.

(g) A discount health plan shall not offer any insurance product, or health care service plan product, in conjunction with the offer of a discount health product. This prohibition includes but is not limited to, radio, television, print, e-mail, and internet advertisements, and disclosure documents and subscriber contracts, that reference discount health products together with any reference to insurance product or insurance terminology. This subsection does not prohibit a California-licensed insurance agent or broker from offering prospective subscribers and enrollees a discount health product as an alternative to, as an optional rider or adjunctive benefit to, an insurance product. All contracts and marketing of a discount health product as an optional rider or an adjunctive benefit to an insurance product shall be disclosed to the Department in the appropriate exhibit to the discount plan's license application.

(h) All discount health plan marketing practices shall comply with the requirements of Sections 1360, 1361, 1363(d), (f) and (g) and 1395(a) of the Act and Sections 1300.51.01(c) (Exhibits Z and AA), 1300.59, 1300.61, 1300.61.3, 1300.76.2, and 1300.85.1 of Title 28, except the plan shall replace terms that apply to health care service plans with terms appropriate for the discount health plan's licensure and operations.

(i) Section 1300.46 of Title 28 shall be applicable to discount health plans. However, neither the discounts offered or otherwise distributed by a discount health plan licensed by the Department, nor the discounts on value added services offered or otherwise distributed by a health care service plan with an existing license for non-discount services, constitute prohibited bonuses or gratuities as contemplated by that section.

(j) References to discounts constitute price advertising within the meaning of Section 1395(a) of the Act, except that, the prohibition in Section 1395(a) to offering a "discount" in advertisements shall not apply to discount health plans that are licensed by the Department and in full compliance with the requirements for such licensure. Advertisement of a "range" of discounts may be allowed only if the plan has obtained approval of the Department prior to use.

(k) Sections 1360 and 1360.1 of the Act shall be applicable to discount health plans, except that the phrase in Section 1360.1 of the Act that states "(other than in a paid advertisement)" shall not apply to discount health plans that are licensed by the Department and in full compliance with the requirements for such licensure.

(l) A discount health plan, or any discount health plan solicitor or solicitor firm which solicits enrollment of subscribers or enrollees, must disclose in all marketing materials and telephone calls, the telephone number for the plan's toll-free customer assistance call center and the availability of interpretation services at the customer assistance call center.

AUTHORITY: Section 1344, Health and Safety Code
REFERENCE: Sections 1352, 1359, 1360, 1360.1, 1361, 1363, and 1395, Health and Safety Code

1300.49.1.4 Requirements Regarding Discounts/Demonstrating Bona Fide Discounts

(a) All discounts described in discount health plan subscriber contracts, disclosure forms, advertisements and other marketing materials shall be amenable to verification that they are bona fide discounts and shall not be subject to terms and conditions that render the promised discount illusory.

(b) In order to constitute a bona fide discount, a discount must meet the following requirements:

(1) The amount billed to the enrollee must meet the following criteria:

(A) The charge must be equivalent to, or less than, the 2009 Medicare Physician Fee Schedule as set forth in 73 Federal Register 69726-70237 (November 19, 2008) and amended by 73 Federal Register 80302-80305 on December 31, 2008, for all services covered by Medicare, relative to the geographic practice area.

(B) For those services not included in the 2009 Medicare Physician Fee Schedule as set forth in 73 Federal Register 69726-70237 (November 19, 2008) and amended by 73 Federal Register 80302-80305 on December 31, 2008, the discount must meet the following conditions:

(i) If a consumer having no contractual relationship with any third-party payor or discount health plan is required to pay the provider the full billed charge for a particular service or product when paying in cash or its equivalent, the discount given to all enrollees and subscribers of a discount health plan for the same service or product from the same provider must be at least 20 percent off of the full billed charge.

(ii) If a consumer having no contractual relationship with any third-party payor or discount health plan is required to pay the provider an amount less than the full

billed charge for a particular service or product when paying in cash or its equivalent, the discount given to all enrollees and subscribers of a discount health plan for the same service or product from the same provider must be at least 20 percent off of that amount.

(iii) If the health care service or product does not meet either (i) or (ii), the discount plan may propose an alternative standard to prove that the discount is bona fide. The plan shall do so by providing a detailed description, in writing, which shall include, but is not limited to, a list of the discounts offered, by service, and a detailed explanation regarding why these discounts should be considered to be bona fide.

(2) The discount must be offered by all providers in the plan's network who provide that service or product.

(3) The discount must be accessible by all subscribers or enrollees to whom the discount health product was marketed.

(4) The terms and conditions upon which the discount is accessible must be disclosed in the subscriber and enrollee documents provided prior to enrollment.

(c) Discount health plans must have sufficient and reliable mechanisms to verify that bona fide discounts are being delivered and are accessible by subscribers and enrollees as described in the subscriber contracts, disclosure forms, advertisements, and other marketing materials. At a minimum, this requires the discount health plan to:

(1) Maintain a toll-free customer assistance call center that provides direct confirmation of provider discounts and pricing information for enrollees.

(2) Maintain a quality assurance program to review information collected through the customer assistance call center and through enrollee grievances regarding problems in the delivery of discounts by network providers.

(3) Take prompt corrective action to address provider non-compliance identified by reviewing the information obtained through the plan's customer service and grievance review processes.

A detailed description of these mechanisms must be submitted with the plan's application under Exhibit J.

(d) Discount health plans shall ensure that enrollees obtain the full, promised discount on covered services that are obtained from any provider listed in the discount health plan's provider directory. If a provider refuses to accept the discounted payment as full payment from the enrollee, the discount health plan shall pay the enrollee the difference between the amount actually billed to the enrollee and the amount the enrollee would have been billed, had the promised discount been applied. The discount health plan shall adjudicate enrollee complaints and grievances through the grievance resolution process in Section 1300.49.1.6. Enrollees shall be reimbursed no later than 30 days following the submittal of a claim.

(e) On July 1 of each year, discount health plans shall file a report under Exhibit J that demonstrates that the discounts offered are bona fide as required by Section 1300.49.1.4(b). At a minimum, this report must include the information relied upon by the discount health plan to support its finding that the discounts are bona fide, as well as a description of the mechanism used to verify that bona fide discounts are accessible by all enrollees. The report must include, but is not limited to, the following information:

(1) The discount applied to each service rendered to enrollees or subscribers of the discount health plan.

(2) Documentation proving that each discount is offered by all providers in the discount health plan's network.

AUTHORITY: Section 1344, Health and Safety Code
REFERENCE: Sections 1342 and 1346, Health and Safety Code

1300.49.1.5 Availability and Accessibility of Discounted Provider Services

(a) A discount health plan shall maintain an accessible and available provider network, including ensuring sufficient numbers of providers with adequate capacity to provide timely appointments for the services on which discounts are advertised. The geographic accessibility standards of 28 CCR Section 1300.67.2.1 shall apply. The timely access standards of 28 CCR Section 1300.67.2.2 shall not apply, except as provided below. A plan may demonstrate compliance with the requirements of this subsection if the plan meets all of the following:

(1) The plan demonstrates the availability of providers in the network, for example, the percentage of providers that are accepting new patients.

(2) The plan maintains a toll-free customer assistance call center that provides direct confirmation of provider availability and acceptance of discount health plan enrollees seeking an appointment.

(3) The plan's quality assurance program includes a review of information collected through the customer assistance call center and through enrollee grievances regarding lack of access and availability.

(4) A discount health plan shall maintain a toll-free customer assistance call center during normal business hours in California to assist enrollees to access services through the plan's network of providers and to address complaints and grievances. Customer assistance shall also be provided to assist enrollees to confirm the discounts and costs for specific services from individual providers.

(5) The plan takes prompt corrective action regarding provider access and availability problems.

(6) The plan's toll-free customer assistance call center shall be sufficiently staffed to ensure that all calls are answered in less than ten minutes by a live person sufficiently trained and knowledgeable regarding the discount health plan's services, discounts, terms, conditions, and processes to ensure effective assistance for callers and to ensure feedback of identified

problems to quality assurance staff, including information reflecting provider non-compliance with contractual obligations.

(b) The provider directory required by Section 1300.49.1.3(d) of this article shall comply with Section 1367.26 and shall also include the address and phone number of each contracted provider.

AUTHORITY: Section 1344, Health and Safety Code
REFERENCE: Sections 1366.1, and 1367.26, Health and Safety Code

1300.49.1.6 Grievance Systems

(a) All discount health plans shall review and resolve enrollee complaints and grievances pursuant to Section 1368 of the Act, and Sections 1300.51(d) (Exhibit W) and 1300.68 of Title 28, except that subsections (b)(7), (d)(4), (d)(5), (f), and (i) of Section 1300.68 shall not apply, and the plan shall replace terms that apply to health care service plans with terms appropriate for the discount health plan's licensure and operations.

(b) All discount health plans shall file quarterly, as an addendum to Exhibit W, all enrollee complaints and grievances during that quarter, and the plan's determinations regarding each complaint and grievance.

AUTHORITY: Section 1344, Health and Safety Code
REFERENCE: Sections 1368, 1368.015, 1368.02, Health and Safety Code

1300.49.1.7 Cancellation and Termination

(a) Discount health plans shall comply with the requirements of Section 1365 of the Act and Sections 1300.65 and 1300.65.1 of Title 28.

(b) A discount health plan shall provide for refund of prepaid or periodic charges upon cancellation of a subscriber contract as follows:

(1) A discount health plan shall provide a period of not less than 30 days following enrollment in which a subscriber may cancel the subscriber contract and obtain full reimbursement of the money paid to the plan, less an amount that represents the plan's actual administrative costs of enrolling the subscriber, such as printing and mailing required disclosures, but which shall not exceed $30.

(2) Upon cancellation of a subscriber contract after the initial 30 days of enrollment, the plan shall, within 30 days, return to the subscriber the pro rata portion of the money paid to the plan which corresponds to any unexpired period for which payment has been received.

(3) For purposes of this section "money paid to the plan" shall include all fees paid to the plan in connection with enrollment, including but not limited to prepaid or periodic charges, enrollment fees, and administrative processing fees. If administrative or other fees are charged to subscribers or enrollees as a one-time fee or as an annual fee, the pro rata refund shall be based on a twelve month contract term.

(c) A discount health plan shall not cancel a subscriber contract or terminate an enrollment under a subscriber contract except for the subscriber's nonpayment of the prepaid or periodic charge, a subscriber's or enrollee's fraud in the use of services and facilities, or such other good cause as agreed upon in the contract between the plan and the group or the subscriber.

AUTHORITY: Section 1344, Health and Safety Code
REFERENCE: Section 1365, Health and Safety Code

1300.49.1.8 Language Assistance

(a) A discount health plan must provide, through its toll-free customer assistance call center, free interpretation services for all languages that are used by the plan, solicitors, and marketers, to direct marketing activities towards persons with limited English proficiency. For purposes of this subsection, the directing of marketing activities towards persons with limited English proficiency includes, but is not limited to, instances where the plan or its solicitors or solicitor firms solicit enrollment in person or by telephone, fax, mail, e-mail, or an on-line web site, in a non-English language. A description of the plan's operational compliance with this section shall be filed under Exhibits Y and Z of the Application.

(b) A discount health plan shall also set forth reasonable procedures for assessing the linguistic needs of its enrollees. This shall include, at a minimum, (1) tracking and compiling enrollee requests for language preference and (2) consideration of California census data. Based on those needs, the plan shall provide;

(i) free interpretation services through its toll-free customer assistance call center. At a minimum, these interpretation services will assist enrollees in understanding the services, terms and conditions of the discount health product, including enrollee rights and responsibilities under the plan's grievance system, and will provide language assistance to enrollees filing a grievance. A description of the plan's compliance with this section shall be filed under Exhibits J and W; and

(ii) the plan shall translate standardized vital documents in writing for those languages identified as threshold languages as defined in Section 1367.04(b)(1)(A) of the Act. All translated vital documents shall be available on the plan's website. The following are considered vital documents:

(A) Consent forms, including any form by which an enrollee authorizes or consents to any action by the plan;

(B) Letters containing important information regarding eligibility and participation criteria;

(C) Notices pertaining to termination of membership, and the right to file a grievance or appeal;

(D) Enrollee ~~Evidence of Coverage and~~ Disclosure Forms as required by Section 1363(a)(1) and (2) of the Act.

(c) The plan shall also provide adequate training for its employees to enable them to identify when a person has limited English proficiency and how to appropriately engage the plan's language assistance services.

(d) A discount health plan must disclose the availability of interpretation services at the customer assistance call center in all marketing materials and telephone calls to potential subscribers or enrollees, all contracts with subscribers or enrollees, and all disclosure forms provided to subscribers or enrollees. Confirmation of compliance with this section shall be filed under Exhibits S, V, Y, and/or Z, as appropriate.

AUTHORITY: Section 1344, Health and Safety Code
REFERENCE: Sections 1367.04, 1368, and 1368.02, Health and Safety Code

1300.49.1.9 Financial and Administrative Requirements

(a) For purposes of Section 1356 and 1356.1, discount health plans shall be required to pay fees and reimbursements to the same extent as specialized plans.

(b) Discount health plans shall demonstrate financial viability for the nature of their operations. The clause in Section 1375.1, subdivision (a)(2) that states "Assumed full financial risk on a prospective basis for the provision of covered health care services" shall not apply to discount health plans that are licensed by the Department and in full compliance with the requirements for such licensure.

(c) All discount health plans shall comply with the administrative capacity requirements of Section 1367(g) of the Act and Section 1300.51.01(c) (Exhibit M) of Title 28, except that the plan shall replace terms that apply to health care service plans with terms appropriate for the discount health plan's licensure and operations.

AUTHORITY: Section 1344, Health and Safety Code
REFERENCE: Sections 1356, 1367, and 1375.1, Health and Safety Code

1300.49.1.10 Subscriber and Enrollee Disclosure Forms

(a) A discount health plan shall file with the Department, not less than 30 days before publication or distribution by the plan or any of its solicitors, a true copy of any new subscriber contract, disclosure form, or description of discounted services.

(b) A discount health plan's product disclosure forms shall comply with the requirements of Sections 1345, 1362, and 1363(a)(1)-(8) and (a)(10) of the Act and Sections 1300.51.01(c) (Exhibit S) and 1300.63.2 of Title 28, except that the plan shall replace terms that apply to health care service plans with terms appropriate for the discount health plan's licensure and operations. The following additional disclosures shall be prominently located on the first (cover) page:

(1) The discount health product is not insurance.

(2) The enrollee must pay the provider directly for all health care purchases, and will receive a discount only from providers that are in the discount health plan network.

(3) That the subscriber or enrollee may be required to pay the provider at the time health care services are rendered, or at the time health related items are received, in order to receive the discount.

(4) That within 30 days of enrollment a subscriber may cancel the subscriber contract and obtain full reimbursement of the money paid to the plan, less an amount that represents the plan's actual administrative costs of enrolling the subscriber, such as printing and mailing required disclosures, but which shall not exceed $30.

(c) A discount health plan's product disclosure forms shall list all services that are discounted, and shall disclose the percentage discount offered on each service listed.

(d) In addition to the disclosures required by subsection (b), disclosure forms reflecting a solicitor's private label name shall include prominent statements on the first (cover) page that distinguish the private labeler as a solicitor for the discount health plan and clearly disclose that enrollment is with the discount health plan.

(e) Discount cards intended for presentation to health care providers as evidence of an enrollee's entitlement to discounts shall contain all of the following:

(1) The name of the discount health plan and the telephone number for its toll-free customer service call center;

(2) A prominent statement that the discount health product is not insurance and the enrollee must pay the provider directly;

(3) Sufficient information to ensure that the network provider will recognize the discount plan and discount health product;

(4) If the discount card contains the name of a private label marketer, prominent statements equivalent to those required by subsection (d).

AUTHORITY: Section 1344, Health and Safety Code
REFERENCE: Sections 1345, 1352, 1352.1, 1362, and 1363, Health and Safety Code

1300.49.1.11 Subscriber Contracts

(a) A discount health plan shall not offer a group contract for any discount product that offers discounts on any of the health care services described in Sections 1345(b) and 1374.72 of the Act and Section 1300.67 of Title 28.

(b) A discount health plan shall maintain a written contract with each subscriber. The Director may permit the subscriber contract and the disclosure form prescribed at Section 1300.49.1.10(a) of this article to be combined and presented in a single document if the purposes of both are fulfilled.

(c) Discount health plan subscriber contracts shall not:

(1) Impose any waiting period or preexisting condition exclusion upon the provision of advertised discounted health care services.

(2) Discriminate against any subscriber or enrollee in the issuance of any subscriber contract for any reason, including but not limited to the enrollee's health status or health history or the reasons set forth at Sections 1367.4, 1367.8, 1365.5, 1373.14; 1374.7; 1374.51, and 1374.75.

(d) A discount health plan's forms of subscriber contracts shall comply with the requirements of Section 1300.51.01(c) (Exhibits P and Q) and 1300.67.4 of Title 28, except the plan shall replace terms that apply to health care service plans with terms appropriate for the discount health plan's licensure.

(e) A discount health plan must include in each subscriber contract the telephone number for the plan's toll-free customer service call center and the availability of interpretation services at the customer service call center. Confirmation of compliance with this section shall be filed under exhibits P or Q, as appropriate.

AUTHORITY: Section 1344, Health and Safety Code
REFERENCE: Sections 1345, 1352.1, 1357.51, 1365, 1365.5, 1367.4, 1367.8, 1373.14, 1374.7, 1374.29, 1374.51, 1374.72, and 1374.75, Health and Safety Code

1300.49.1.12 Provider Contracts

(a) A discount health plan shall maintain a written contract with each provider offering discounts on health care purchases to the discount health plan's subscribers and enrollees.

(1) The provider contract may be entered into directly with individual providers or indirectly through either one or more provider networks that maintain written contracts with individual providers, or other discount health plans that maintain written contracts with such networks. The discount health plan shall document that each provider has been notified of, and agrees to, the terms of the discount product prior to inclusion in the provider directory. The provider contract shall require verification that all provider billing affiliates have also been notified of, and agree to bill according to, the terms of the discount product.

(2) In reviewing the compliance of a discount health plan's contracted provider network, the Department may consider whether or not the plan's arrangements are so complex and/or attenuated that they render the discount health plan unable to reasonably maintain effective oversight and monitoring for the network's compliance with the requirements of this Article.

(b) The contract must include all of the following:

(1) A list of the services to be provided at a discount.

(2) Either the amount, or amounts, of the discount or a fee schedule that reflects the provider's discounted rates.

(3) A statement that the provider will not charge members more than the discounted rates.

(c) A discount health plan's forms of provider contract shall comply with the requirements of Sections 1367(a), (b), and (c) of the Act and Sections 1300.51.01(c) (Exhibit K) and 1300.67.8(a), (b), (c), and (d) of Title 28, except the plan shall replace terms that apply to health care service plans with terms appropriate for the discount health plan's licensure. Provider contracts shall also contain terms and conditions sufficient to enable the plan:

(1) To verify that providers are delivering bona fide discounts to enrollees as advertised.

(2) To enforce the provision of discounts by the individual providers in its contracted networks.

(3) To require the provider to disclose, to the extent feasible for the nature of the services specific pricing information to plan enrollees upon request before the service is rendered.

(d) A provider agreement between a discount health plan and a provider network shall require that the provider network have written agreements with its providers that:

(1) Conform to the requirements of subsections (b) and (c).

(2) Authorize the provider network to contract with the discount health plan on behalf of the provider.

(3) Require the provider network to maintain an up-to-date list of its contracted providers (including license and certificate numbers, where applicable) and to provide the list on a quarterly basis to the discount health plan.

(e) The discount health plan shall maintain an executed copy of each active provider agreement into which it has entered, and shall make the contracts available for the Department's inspection upon request.

AUTHORITY: Section 1344, Health and Safety Code
REFERENCE: Sections 1367, 1367.8, 1375.6, 1375.7, 1379, and 1395.6, Health and Safety Code